Remarks of Henry A. Waxman, Chairman
Subcommittee on Health and the Environment
before the
American Academy of Family Physicians
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Thank you for inviting me to join you tonight.

Last November, the Congress enacted two major initiatives: Medicare physician payment reform, and a Federal program for outcomes research and the development of clinical practice guidelines.

I want to take this opportunity to thank you personally for your leadership and constructive cooperation on these initiatives. At this time last year, it was by no means certain that we would be able to enact such far-reaching legislation. Some people, including the Administration, were urging us to take more time to review the issues. Without the firm support of the Academy, and a few other prominent groups, I doubt we would have been so successful.

I want to talk with you this evening about these two initiatives, and about the National Health Service Corps. Then I'd like to close with some thoughts about access to health care for the uninsured.

Medicare

Let's start with Medicare.

Last year saw the culmination of several years' work on RB RVS payment reform in Medicare.

It's obvious that these reforms will significantly change the environment within which physicians practice medicine. There will be changes in the methods for payment. There will be changes in the amounts of payment. And Medicare will begin to focus more intently on what it is paying for, and under what condition services are being furnished.

As we move to a system of administered prices, Medicare will have to be more careful in defining what is included in, or excluded from, the service for which the price has been established.

As a result of the RBRVS reform, some physicians will receive lower revenues from Medicare, while other physicians will receive more. But all physicians will be more closely monitored by Medicare in how they practice medicine.

I supported both the RB RVS payment reform and the development of clinical practice guidelines and medical review criteria. But I continue to have serious misgivings about the so-called "volume performance standards," which were adopted at the insistence of the Bush Administration.

As you know, these are targets for the total expenditures for physician services under Medicare for a twelve month period. If total expenditures exceed the target, then the annual update in physician fees two years later is supposed to be reduced accordingly. The target for this year has been set at 9.1 percent. It is almost certain to be exceeded, and two years from now payments will be reduced accordingly. The Secretary's recommended target for 1991 is 9.9 percent.

My concern is that we have put the cart before the horse. We have established the target, retroactively, before the physician community has the tools to monitor itself and work cooperatively to reduce the rate of increase. Physicians who are delivering appropriate care will face the same financial penalty as those who are abusing the program, yet there is little that the responsible physicians can do to protect themselves.

Volume performance standards are irrational and unfair. But the budgetary reality is that they will be with us so long as the rates of increase in Medicare expenditures continue to exceed 10 percent each year.

Looking at the Subcommittee's agenda this year, I do not expect any Medicare legislation of comparable scope. Instead, we will be monitoring the implementation of payment reform and the development of clinical practice guidelines.

It also appears that we will have to make further cuts in Medicare, since the House Budget Committee's FY 91 budget assumes that we will lower Medicare outlays by $1.7 billion next year. This is far less than the $5.5 billion in cuts that the Bush Administration is demanding. It is also the same amount that Medicare would lose if the Congress failed to come up with a budget and the automatic Gramm-Rudman budget cuts went into effect.

I am going to make every effort to assure that the Medicare cuts we are forced to enact will not undermine payment reform.

Before leaving the issue of payment reform, let me drop a footnote for you about a related Medicaid change that was also enacted last November. I have been pushing for several years to improve the ability of the Medicaid program to improve access to prenatal and maternity care for high-risk women and infants. One of Medicaid's well-known shortcomings is low reimbursement, especially for physicians.

Last November's legislation directs the States to assure that, for obstetrical and pediatric services, the payment rates be sufficient to ensure adequate provider participation. Family practitioners are among the specialties identified as needing reimbursement upgrades. The legislation does not specify a particular payment methodology or rate; these decisions will continue to be made by the individual States. However, we have asked the Physician Payment Reform Commission to look at what the States are doing and whether RB RVS principles should be applied to the Medicaid program.

There are some other Medicare issues on the Subcommittee agenda. We are hearing more and more concern being expressed about how the Medicare program affects patients and physicians. Issues are being raised regarding quality of care, utilization review, and other administrative requirements.

The Institute of Medicine has recently released an important study, requested by Congress, which proposes major changes in the quality assurance for the Medicare program. I expect that our Subcommittee will want to explore this in some detail.

Last month, the Subcommittee held a hearing in Atlanta which highlighted some of the concerns about the administration of the Part B program by the carriers. This will continue to receive the attention of the Subcommittee.

Outcomes Research/Clinical Practice Guidelines

I believe the RB RVS payment reforms will improve the mix of services provided to Medicare patients. But even more important in this respect will be the work of the new Agency of Health Care Policy and Research. The major focus of the new agency is to conduct and support research on the most effective way of diagnosing and treating various patient conditions. It has a broader charter and significantly greater resources than was previously available for health services research and technology assessment.

The work of this new agency is to focus on clinical practice, with one of its highest priorities being primary care and practice-oriented research. Again, I want to acknowledge and commend the Academy for pressing these concerns and for working with us to bring them to fruition.

National Health Service Corps

Let me turn next to an issue that the Subcommittee will be taking up this month: reauthorization of the National Health Service Corps.

As you know, the Corps is the program through which the Federal government has, since 1970, tried to meet the needs of underserved urban and rural areas for primary care physicians and other health professionals.

There are about 12.5 million Americans living in areas without primary health care. The problem is not that these Americans are uninsured; many of them have public or private coverage. The problem is that there are simply no primary care doctors or other health professionals serving the communities in which they live. At the same time that over 1900 rural and urban areas are underserved, there are many communities with a surplus of physicians. This is indefensible.

Unfortunately, due to a bad decision we made in the early 1980's to phase out the scholarship program, the Corps is no longer able to meet the needs of most underserved communities. To eliminate the current shortages would require 4,200 primary care physicians. This year, the Corps hopes to place 1,750 physicians and other health professionals in underserved areas. There are only 123 scholarship recipients available for placement. By 1993, this number will decline to 18.

The logic of these numbers is obvious. Unless we revitalize the Corps, we will leave millions of rural and inner-city Americans stranded without access to primary care. We need to revitalize the Corps, focussing it on developing primary care physicians and mid-level practitioners committed to service in underserved areas.

I've joined with Congressman Bill Richardson from New Mexico and other members of the Committee in sponsoring a bill, H.R. 4487, to revitalize the Corps. The Academy has been very helpful in the development of legislation, and I look forward to your continued support as we move to enactment.

Health Care for the Uninsured

Finally, let me turn to the issue of the uninsured. We have over 31 million citizens who have no public or private insurance coverage. And the Census Bureau recently reported that 63 million Americans went without health insurance coverage sometime during a 28 month period. That's almost 30 percent of our population!

Last month, the Pepper Commission recommended a $23 billion program to extend basic health care coverage to the uninsured, using a combination of employer-based insurance and a new public program for those without employer coverage. The Commission also proposed a $34 billion long-term care program.

I was a member of the Pepper Commission and I support its recommendations. They are not perfect. I had hoped that the cost containment provisions would be stronger, and that the States could be relieved of their current financial responsibility for acute care services under the public program.

But the Commission's recommendations will frame the Congressional debate on the uninsured. I believe that they are not just a starting point for discussion, but that they are a blueprint for what the Congress will ultimately legislate in this area. There is little support in the Congress for a Canadian-style approach, and there is increasing impatience with the status quo. The only viable alternative is to start with what we have -- an employer-based, privately administered insurance system -- and build upon that.

The problem now is leadership. Those with the responsibility to lead -- President Bush and his Administration -- have run for cover behind study commissions. The Chairman of the Pepper Commission, Senator Rockefeller, is doing all that he can to develop a consensus in the Congress around the Commission's recommendations. But he cannot make up for the leadership failure in the White House.

Conclusion

One of my goals since coming to Congress in 1974 has been to make primary care available to all Americans -- urban and rural, affluent and poor. I believe it will yield large benefits in improvement of health status and avoidance of health care costs. There are many different pieces of the primary care puzzle: Medicare and Medicaid reimbursement, outcomes research and clinical practice guidelines, and manpower programs such as the National Health Service Corps. As we enter the 1990's, I look forward to continuing to work with you in the family physician community in all of these areas to increase access to quality primary care.